Department of HUMAN SERVICES

Integrated Health Home Workgroup Meeting March 2, 2022

March 2, 2022

Role Call

Format of Workgroup

- Discuss prior meeting (high level)
- Topic for the meeting
- Plan and expectations for next meeting

It is ok to ask questions during the meeting and between meetings. These questions and answers will be shared at the beginning of each meeting.

What is Our Why? What Do We Want to Accomplish?

- Identify how the Health Homes meet the provider standards set forth by the federal government as well as identify appropriate oversight of those standards.
- Develop a proposal for a payment methodology that is consistent with the goals of efficiency, economy, and quality of care. The rate will be developed according to the actual cost of providing each component of the service.
- Review member qualifications in order to propose qualifications that meets federal and state code.
- Update Health Home Services to reflect whole-person team based-care while reducing provider burden.
- Develop a Quality Improvement model that can be adopted by Integrated Health Homes.
- Develop a proposal to present to the State that encompasses all the forementioned goals.

Ground Rules

- You can respect another person’s point of view without agreeing with them.
- Respectfully challenge the idea, not the person and bring potential solutions.
- Blame or judgment will get you further from a solution, not closer.
- Honest and constructive discussions are necessary to get the best results.
- Listen respectfully, without interrupting.
- Listen actively and with an ear to understanding others' views. (Don’t just think about what you are going to say while someone else is talking.)
- Commit to learning, not debating. Comment in order to share information, not to persuade.
- Avoid blame, speculation, and inflammatory language.
- Allow everyone the chance to speak.

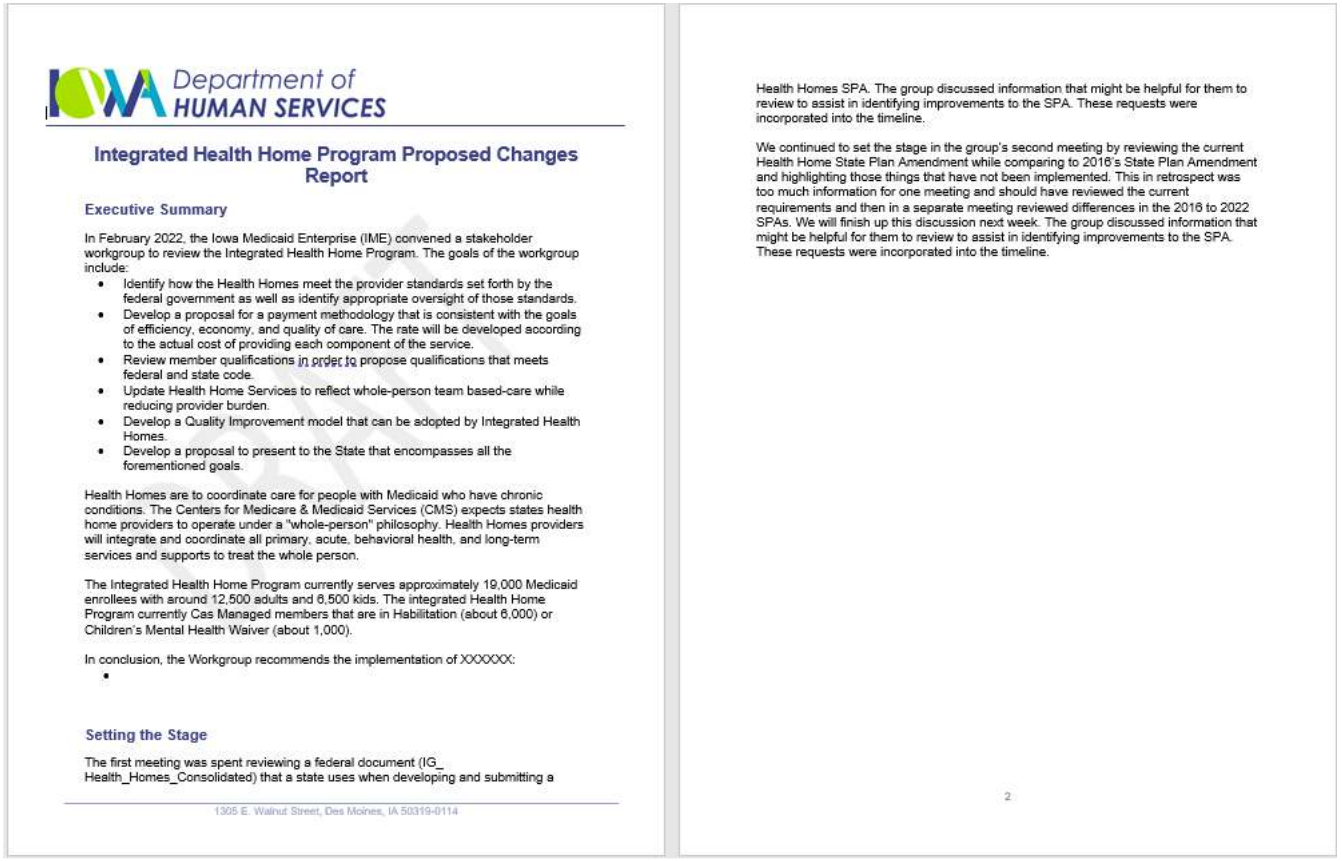
Objectives

- Review of Last Meeting
- Workgroup Report
- Integrated Health Home SPA
  - What are we meeting now?
  - What changes were made and why? (Added, Edited, or deleted)
  - Flow chart of what is the authority (Federal code, Iowa code, SPA…)
  - Include SPA from 2016 as supporting documentation.
- Iowa Administrative Rule

Last Meeting

- Reviewed the timeline and plan for the next few months
- Reviewed much of the current SPA along with what has changed from the previous SPA and what still needs implemented.
- Plan for the next meeting and discussed what may be needed to support the work
- Questions/Answers

Workgroup Report



Department of HUMAN SERVICES

Integrated Health Home Program Proposed Changes Report

Executive Summary

In February 2022, the Iowa Medicaid Enterprise (IME) convened a stakeholder workgroup to review the Integrated Health Home Program. The goals of the workgroup include:

- Identify how the Health Homes meet the provider standards set forth by the federal government as well as identify appropriate oversight of those standards.
- Develop a proposal for a payment methodology that is consistent with the goals of efficiency, economy, and quality of care. The rate will be developed according to the actual cost of providing each component of the service.
- Review member qualifications in order to propose qualifications that meets federal and state code.
- Update Health Home Services to reflect whole-person team based-care while reducing provider burden.
- Develop a Quality Improvement model that can be adopted by Integrated Health Homes.
- Develop a proposal to present to the State that encompasses all the forementioned goals.

Health Homes are to coordinate care for people with Medicaid who have chronic conditions. The Centers for Medicare & Medicaid Services (CMS) expects states health home providers to operate under a "whole-person" philosophy. Health Homes providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

The Integrated Health Home Program currently serves approximately 19,000 Medicaid enrollees with around 12,500 adults and 6,500 kids. The integrated Health Home Program currently Cas Managed members that are in Habilitation (about 6,000) or Children's Mental Health Waiver (about 1,000).

In conclusion, the Workgroup recommends the implementation of XXXXXX:

-

Setting the Stage

The first meeting was spent reviewing a federal document (IG_ Health_Homes_Consolidated) that a state uses when developing and submitting a

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Health Homes SPA. The group discussed information that might be helpful for them to review to assist in identifying improvements to the SPA. These requests were incorporated into the timeline.

We continued to set the stage in the group's second meeting by reviewing the current Health Home State Plan Amendment while comparing to 2016's State Plan Amendment and highlighting those things that have not been implemented. This in retrospect was too much information for one meeting and should have reviewed the current requirements and then in a separate meeting reviewed differences in the 2016 to 2022 SPAs. We will finish up this discussion next week. The group discussed information that might be helpful for them to review to assist in identifying improvements to the SPA. These requests were incorporated into the timeline.

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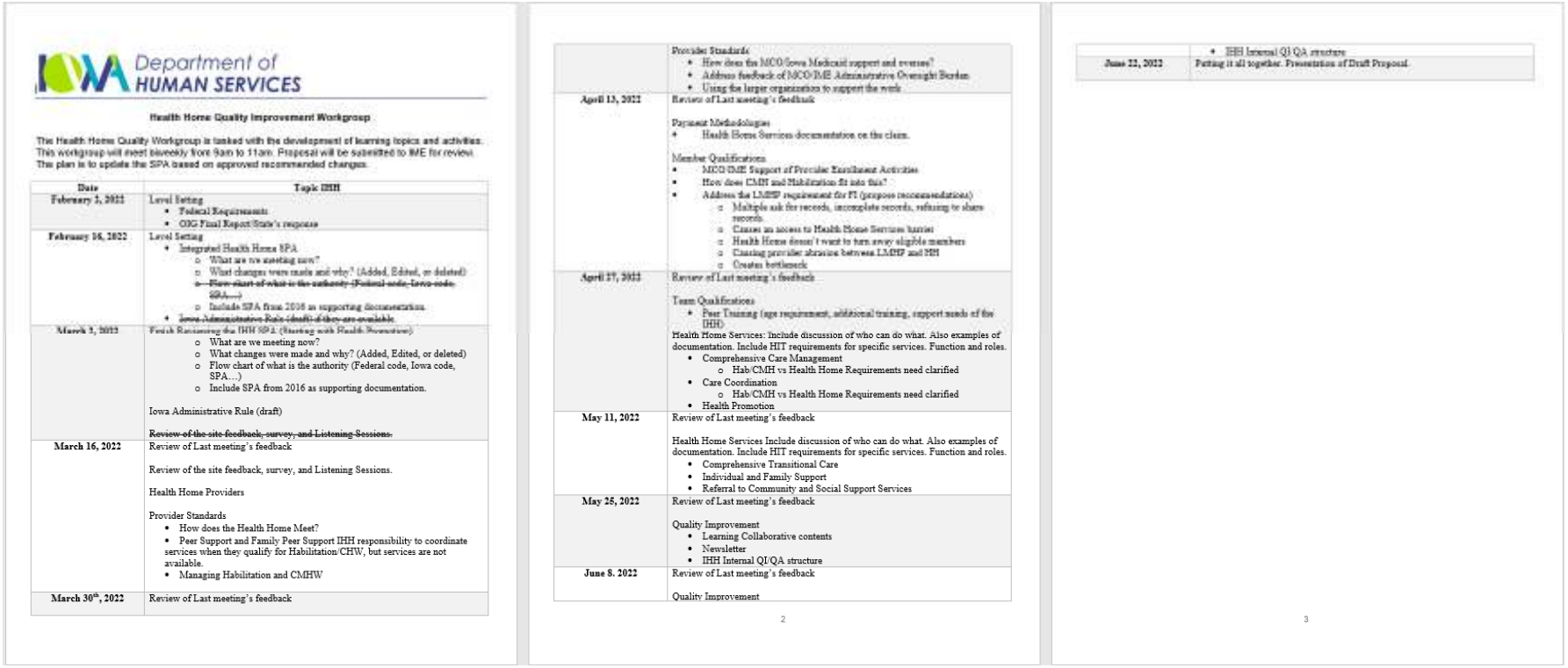
Overview of the Timeline



Department of HUMAN SERVICES

Health Home Quality Improvement Workgroup

The Health Home Quality Workgroup is tasked with the development of learning topics and activities. This workgroup will meet biweekly from 9am to 11am. Proposal will be submitted to IME for review. The plan is to update the SPA based on approved recommended changes.

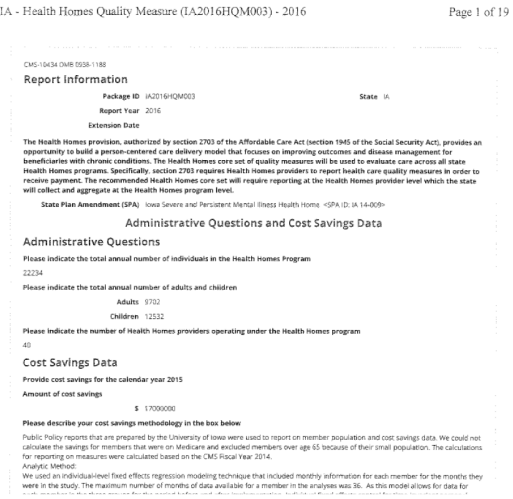
Date	Topic IHH
February 2, 2022	Level Setting • Federal Requirements • OIG Final Report/State's response
February 16, 2022	Level Setting • Integrated Health Home SPA o What are we meeting now? o What changes were made and why? (Added, Edited, or deleted) o ~~Flow chart of what is the authority (Federal code, Iowa code, SPA…)~~ o Include SPA from 2016 as supporting documentation. • ~~Iowa Administrative Rule (draft) if they are available~~
March 2, 2022	~~Finish Reviewing the IHH SPA (Meeting with Health Promotion)~~ o What are we meeting now? o What changes were made and why? (Added, Edited, or deleted) o Flow chart of what is the authority (Federal code, Iowa code, SPA…) o Include SPA from 2016 as supporting documentation. Iowa Administrative Rule (draft) ~~Review of the site feedback, survey, and Listening Sessions.~~
March 16, 2022	Review of Last meeting's feedback Review of the site feedback, survey, and Listening Sessions. Health Home Providers Provider Standards • How does the Health Home Meet? • Peer Support and Family Peer Support IHH responsibility to coordinate services when they qualify for Habilitation/CHW; but services are not available. • Managing Habilitation and CMHW
March 30th, 2022	Review of Last meeting's feedback
	Provider Standards • How does the MCO/Iowa Medicaid support and oversee? • Address feedback of MCO/IME Administrative Oversight Burden • Using the larger organization to support the work
April 13, 2022	Review of Last meeting's feedback Payment Methodologies • Health Home Services documentation on the claim. Member Qualifications • MCO/IME Support of Provider Enrollment Activities • How does CMH and Habilitation fit into this? • Address the LMHP requirement for FI (propose recommendations) o Multiple ask for records, incomplete records, refusing to share records o Causes an access to Health Home Services barrier o Health Home doesn't want to turn away eligible members o Causing provider abrasion between LMHP and HH o Creates bottleneck
April 27, 2022	Review of Last meeting's feedback Team Qualifications • Peer Training (age requirement, additional training, support needs of the IHH) Health Home Services: Include discussion of who can do what. Also examples of documentation. Include HIT requirements for specific services. Function and roles. • Comprehensive Care Management o Hab/CMH vs Health Home Requirements need clarified • Care Coordination o Hab/CMH vs Health Home Requirements need clarified • Health Promotion
May 11, 2022	Review of Last meeting's feedback Health Home Services Include discussion of who can do what. Also examples of documentation. Include HIT requirements for specific services. Function and roles. • Comprehensive Transitional Care • Individual and Family Support • Referral to Community and Social Support Services
May 25, 2022	Review of Last meeting's feedback Quality Improvement • Learning Collaborative contents • Newsletter • IHH Internal QI/QA structure
June 8. 2022	Review of Last meeting's feedback Quality Improvement
	• IHH Internal QI QA structure
June 22, 2022	Putting it all together. Presentation of Draft Proposal.

Documents for Today


Department of HUMAN SERVICES

Integrated Health Homes 2022

January 2022


IA - Health Homes Quality Measure (IA2016HQM003) - 2016 Page 1 of 19

CMS-10434 OMB 0938-1188

Report Information

Package ID IA2016HQM003 State IA

Report Year 2016

Extension Date

The Health Homes provision, authorized by section 2703 of the Affordable Care Act (section 1945 of the Social Security Act), provides an opportunity to build a person-centered care delivery model that focuses on improving outcomes and disease management for beneficiaries with chronic conditions. The Health Homes core set of quality measures will be used to evaluate care across all state Health Homes programs. Specifically, section 2703 requires Health Homes providers to report health care quality measures in order to receive payment. The recommended Health Homes core set will require reporting at the Health Homes provider level which the state will collect and aggregate at the Health Homes program level.

State Plan Amendment (SPA) Iowa Severe and Persistent Mental Illness Health Home <SPA ID: IA 14-009>

Administrative Questions and Cost Savings Data

Administrative Questions

Please indicate the total annual number of individuals in the Health Homes Program

22234

Please indicate the total annual number of adults and children

Adults 9702

Children 12532

Please indicate the number of Health Homes providers operating under the Health Homes program

40

Cost Savings Data

Provide cost savings for the calendar year 2015

Amount of cost savings

$ 17000000

Please describe your cost savings methodology in the box below

Public Policy reports that are prepared by the University of Iowa were used to report on member population and cost savings data. We could not calculate the savings for members that were on Medicare and excluded members over age 65 because of their small population. The calculations for reporting on measures were calculated based on the CMS Fiscal Year 2014.
Analytic Method:
We used an individual-level fixed effects regression modeling technique that included monthly information for each member for the months they were in the study. The maximum number of months of data available for a member in the analyses was 36. As this model allows for data for


ARC 6206C

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Proposing rule making related to integrated and chronic health homes and providing an opportunity for public comment

The Human Services Department hereby proposes to amend Chapter 77, "Conditions of Participation for Providers of Medical and Remedial Care," Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," and Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is proposed under the authority provided in Iowa Code section 249A.4.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code section 249A.4.

Purpose and Summary

The Department is proposing to update rules for Integrated Health Homes and for Chronic Health Homes based on the deficiencies identified in the audit completed in 2019 by the Office of Inspector General (OIG) for the Health Home (HH) programs for the state fiscal years 2013 through 2016.

The proposed amendments clarify the standards and requirements for the delivery of Health Home services. The audit recommended the Department improve its monitoring of the HH programs to ensure that HH providers comply with federal and state requirements for maintaining documentation to support the services for which the providers billed and received payments. The audit also recommended the Department revise the state plan to define the documentation requirements that HH providers must follow to bill and receive higher in-home health payments for intensive services and educate providers on these requirements. Recommendations were also made that the state plan be revised to define the documentation requirements the HH providers must follow to bill and receive payments for outreach services and also educate providers on these requirements.

State plan amendments have now been submitted and approved. The Department developed an ongoing audit process to be completed by Iowa Medicaid and the managed care organizations that ensure the HH services are appropriately documented. Iowa Medicaid hosted a face-to-face training and plans additional opportunities for training providers on core services and documentation. Monthly webinars, biannual face-to-face training and individual technical assistance based on provider needs have been implemented.

Fiscal Impact

This rule making has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rule making, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 441—1.8(17A,217).

1

Health Promotion

Health Promotion means the education and engagement of an individual in making decisions that promotes health management, improved disease outcomes, disease prevention, safety, and an overall healthy lifestyle.

Health Promotion

- Promoting members' health and ensuring that all personal health goals are included in person-centered care management plans
- Promotion of substance abuse prevention, smoking prevention and cessation, nutritional counseling, obesity reduction, and increased physical activity
- Providing health education to members and family members about preventing and managing chronic conditions using evidence-based sources
- Provide prevention education to members and family members about health screening, childhood developmental assessments and immunization standards
- Providing self-management support and development of self-management plans and/or relapse prevention plans so that members can attain personal health goals

Health Promotion

- Using motivational interviewing, trauma-informed care, and other evidenced based practices to engage and help the member in participating and managing their own care
- Promoting self-direction and skill development in the area of independent administering of medication and medication adherence
- Provide prevention education to members and family members about health screening, childhood developmental assessments and immunization standards
- Increasing health literacy and self-management skills (i.e., WRAP)
- Education or training in self-management of chronic diseases

Health Promotion (HIT)

The patient-centered care plan will be used to plan, communicate, and document individualized goals, interventions, and track status.

Continuity of Care Documents will be useful in tracking treatment progress and coordination with providers. (removed when available, 2016)

Health Promotion (Team)

- Nurse Care Managers will be responsible for the oversight of this service
- Care Coordinators can assist the Nurse Care Manager with the delivery of this service
- Peer support specialist may assist with this service through peer lead programs i.e., Wellness Recovery Action Plan (WRAP)
- The Lead Entity assists the IHH in performing health promotion

Comprehensive Transitional Care

Comprehensive transitional care is the facilitation of services for the individual and supports when the member is transitioning between levels of care (nursing facility, hospital, rehabilitation facility, community-based group home, family, or self-care, another Health Home).

Comprehensive Transitional Care

- Engage member and/or caregiver as an alternative to emergency room or hospital care
- Facilitate development of crisis plans
- Monitor for potential crisis escalation/need for intervention
- Follow-up phone calls and face-to-face visits with members/families after discharge from the emergency room or hospital
- Identification and linkage to long-term care and home and community-based services
- Develop relationships with hospitals and other institutions and community providers to ensure efficient and effective care transitions
- Provide prompt notification of member's admission/ discharge to and from an emergency department, inpatient residential, rehabilitative, or other treatment settings to the member's medical care physician and community support providers with the intent of coordinating care
- Active participation in discharge planning to ensure consistency in meeting the goals of the member's person-centered plan
- Communicating with and providing education to the provider where the member is currently being served and the location where the member is transitioning

Comprehensive Transitional Care

- Ensure the following:
  - Receipt of a CCD from the discharging entity Medication reconciliation
  - Reevaluation of the care plan to include and provide access to needed community supports that includes short-term and long-term care coordination needs resulting from the transition
  - Plan to ensure timely scheduled appointments
- Facilitate transfer from a pediatric to an adult system of health care
- The Teams of Health Care Professionals shall establish personal contact with the member regarding all needed follow-up after the transition

Comprehensive Transitional Care (HIT)

The Lead Entity will provide electronic and telephonic notifications of hospitalizations 24/7.

Care coordination plans and member profiles (including a medication list) are available via the Lead Entity secure portal to support all IHH team members and providers in transitional care management, medication reconciliation, and follow-up care

Comprehensive Transitional Care (Team)

- Nurse Care Managers will be responsible for the oversight of this service
- Care Coordinators can assist the Nurse Care Manager with the delivery of this service
- Peer support specialist may assist with this service through peer lead programs service activities include, but are not limited to:
  - Engage member and/or caregiver as an alternative to emergency room or hospital care
  - Participate in development of crisis plans
  - Monitor for potential crisis escalation/need for intervention
  - Follow-up phone calls and face-to-face visits with members/families after discharge from the emergency room or hospital
- The Lead Entity MD/DO, and Psychiatrists at the Lead Entity may also support transitional activities by providing consultation as needed and participating in development of crisis plans

Individual and Family Support

Individual and Family Support Services include communication with member, family, and caregivers to maintain and promote the quality of life with particular focus on community living options. Support will be provided in culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives.

Individual and Family Support

- Providing assistance to members in accessing needed self-help and peer/family support services
- Advocacy for members and families
- Education regarding concerns applicable to the member
- Education or training in self-management of chronic diseases
- Family support services for members and their families
- Assisting members to identify and develop social support networks
- Assistance with medication and treatment management and adherence
- Identifying community resources that will help members and their families reduce barriers to their highest level of health and success
- Linkage and support for community resources, insurance assistance, waiver services
- Connection to peer advocacy groups, family support networks, wellness centers, NAMI and family Psychoeducational programs
- Assisting members in meeting their goals

Individual and Family Support (HIT)

An IHH member website is available to all IHH enrollees, potential enrollees, their families and supports. The member website contains evidence-based health information about medical and behavioral conditions, medications, and treatment options as well as resources and links for national and local support programs and resources.

Individual and Family Support (Team)

- Nurse Case Managers or Care Coordinators at the IHH will be responsible for the oversight of this service and must be noted in the person-centered care plan
- The Lead Entity assists the IHH in performing individual and family support
- Peer Support or Family Peer Support Specialist, may assist with the following individual and Family support services:
  - Providing assistance to members in accessing needed self-help and peer/family peer support services
  - Advocacy for members and families
  - Family support services for members and their families
  - Assisting members to identify and develop social support networks
  - Support medication adherence efforts
  - Identifying community resources that will help members and their families reduce barriers to their highest level of health and success
  - Linkage and support for community resources, insurance assistance, waiver services
  - Connection to peer advocacy groups, family support networks, wellness centers, NAMI and family psycho educational programs
  - Assisting members in meeting their goals

Referral to Community and Social Support Services

Referral to Community and Social Support Services includes coordinating or providing recovery services and social health services available in the community, such as understanding eligibility for various healthcare programs, disability benefits, and identifying housing programs.

Referral to Community and Social Support Services

- Resources to reduce barriers to assist members in achieving their highest level of function with independence
- Primary care providers and specialists
- Wellness programs, including tobacco cessation, fitness, nutrition or weight management programs, and exercise facilities or classes
- Specialized support groups (i.e., cancer or diabetes support groups, NAMI psychoeducation)
- School supports
- Substance treatment links in addition to treatment -- supporting recovery with links to support groups, recovery coaches, and 12-step programs
- Iowa Department of Public Health (IDPH) Programs

Referral to Community and Social Support Services

- Housing services Housing and Urban Development (HUD), rental assistance program through the Iowa Finance authority
- Food Assistance Iowa Department of Human Services (DHS), Food Bank of Iowa
- Transportation services (NEMT), free or low-cost public transportation
- Programs that assist members in their social integration and social skill building
- Faith-based organizations
- Employment and educational programs or training, Iowa Workforce Development (IWD), Iowa Vocational Rehab Services (IVRS)
- Volunteer opportunities
- Monitor and follow-up with referral source, member, and member's support to ensure that members are engaged with the service

Referral to Community and Social Support Services (HIT)

The person-centered care plan will be used to plan and manage referrals for community and social support services. Evidence-based care guidelines are also provided for use by Health Home teams and providers.

The IHH member website is available to all IHH enrollees, their families and supports as well as providers and Health Home teams. It contains links for information about community and national support services and resources.

Referral to Community and Social Support Services (Teams)

- Nurse Case Managers or Care Coordinators at the IHH will be responsible for the delivery of this service and must be noted in the person-centered care plan.
- Peer Support Specialist or Family Support Specialist
  - Support the member to participate in social supports
- The Lead Entity assists the IHH in performing referral to community and social support services

Health Homes Monitoring, Quality Measurement, and Evaluation

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications.

This was updated from the 2016 SPA because Telligen completes this analysis vs U of I PPC and the methodology is different.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Home program, including data sources and measurement specifications.

This was updated from the 2016 SPA because Telligen completes this analysis vs U of I PPC and the methodology is different.

Describe how the State will use health information technology in providing Health Home services and to improve service delivery and coordination across the care continuum.

The Lead Entity will provide technology infrastructure for health information exchange to be utilized by the Health Homes in order to facilitate collaboration. These capabilities include but are not limited to; member screening and risk stratification, and a web-based profile that integrates Medicaid claims, member self-reported information, and clinical documentation. The Lead Entity will be responsible for sharing health utilization and claims data with the Health Homes to facilitate care coordination and prescription monitoring for members receiving Health Home services. A member website will be available to Health Home enrollees, their families, and supports. It will contain evidence-based information on conditions, health promotion and wellness information, and links to resources.

Describe how the State will use health information technology in providing Health Home services and to improve service delivery and coordination across the care continuum. Cont.

As a part of the minimum requirements of an eligible provider to operate as a health Home, the following relate to HIT:

- Demonstrate use of a population management tool (patient registry) and the ability to evaluate results and implement interventions that improve outcomes over time
- Demonstrate evidence of acquisition, instillation, and adoption of an EHR, system and establish a plan to meaningfully use health information in accordance with federal law
- Provide 24/7 access to the care team that includes but is not limited to a phone triage system with appropriate scheduling during and after regular business hours to avoid unnecessary emergency room visits and hospitalizations
- Utilize email, text, messaging, patient portals and other technology as available to communicate with other providers

Describe how the State will collect information from the Health Homes providers for purposes of determining the effect of the program on reducing the following:

- Hospital Admission Rates
- ER Visit
- SNF Admissions

Measure Specification, including a description of the numerator and denominator. The State will consolidate data from Medicaid claims and encounter data and monitor the difference in incidence rates between enrolled Health Home Members and like non-enrolled members. (Measure calculations may be impacted by Medicare data availability)

Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:

- Hospital Admission Rates (same as previous slide)
- Chronic Disease Management
  - Clinical data received from providers on Health Home enrollees will provide the best picture for this evaluation.
- Coordination of Care for Individuals with Chronic Conditions
  - Clinical data received from providers on Health Home enrollees will provide the best picture for this evaluation.
- Assessment of Program Implementation
  - This will consist of a review of the program administrative costs, reported member outcomes, and overall program cost savings and **member surveys**. An evaluation that details the process of implementation, as well as the challenges experienced and adaptations that were made during the implementation will be undertaken.

Dashboards

Priority	Measure
Structure	Lead Entity Self-Assessment
	Health Home Self-Assessment
Process	Health Home Dashboard
	A15 Report
	CSR Report
	Level of Care Report
Outcomes	Member Surveys
	Performance Measures
	CMS Health Home Core Measures
	Chart Review Results

Priority	Measure
Structure	Health Home Self-Assessment
Process	Health Home Dashboard
Outcomes	Member Surveys
	Performance Measures
	CMS Health Home Core Measures
	Chart Review Results

Processes and Lessons Learned

An evaluation that includes provider and member input on the Health Home Program will inform the state on ways to improve the process.

The State Medicaid Agency and the Lead Entity will continue to develop tools to capture feedback from the Health Homes to document and understand any operational barriers to implementing Health Home Services.

As more successful Health Homes are identified via clinical data and claims data, implementation guidelines and suggestions will be documented and trained to further promote success statewide.

Assessment of Quality Improvements and Clinical Outcomes

An evaluation that includes provider and member input on the Health Home Program will inform the state on ways to improve the process.

An evaluation of clinical data shared by providers will allow the state to adjust the clinical outcome measures to ensure the optimal results and continued improvement.

What is the authority?

Authority Flow

- Federal Code
- Federally Approved State Plan/Waivers
- State Administrative Code

State Administrative Code can be more strict but not more lenient than Federal Code.

The key is to follow the stricter requirement.

Administrative Rule

Chapter 77.47 Rescind and Replace

77.47(1) Definitions

- Functional impairment
- Health home
- Integrated health home
- Lead entity
- Managed care organization
- Serious emotional disturbance
- Serious mental illness

441--77.47 (3) *Integrated Health Home Provider Qualifications.*

- Provider types that can be enrolled
- Requirements to enroll as a Health Home
- Staffing requirements

441--77.47 (4) *Lead Entity Qualifications*

- Identifies who can be enrolled as a Lead Entity
- Requirements to enroll as a Lead Entity
- Staffing requirements

77.47(5) Health Home General Requirements

Applies to both IHH and CCHH

- Whole-person orientation
- Coordinated integrated care
- Enhanced Access
- Emphasis on Quality and Safety
- Case Management (IHH Only)
- Policies and procedures
- Report on quality measures
- Health Home termination

Chapter 78.53 Rescind and Replace

441—78.53 (249A) Health home services

- Health Home
- Integrated Health Home
- Patient-Centered Care Plan
- Person-Centered Service Plan or Service Plan

78.53(2) Covered services

Applies to both IHH and CCHH

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support
- Referral to Community and Social Support Services

78.53(3) Member eligibility for health home services

Integrated health home eligible member criteria. To be eligible for integrated health home services, the member must have a serious mental illness or serious emotional disturbance, as such terms are defined in rule 441-77.47(1).

78.53(4) Member Identification and Enrollment

Both IHH and CCHH

- Member identification
- Member must be informed about the Health Home Program and how to opt-out.
- Members must agree
- Eligibility must be assessed on an annual basis

78.53 (5) Health home documentation

Both IHH and CCHH

- Eligibility
- Comprehensive Assessment
- Person-centered service plan (IHH only) and patient-centered care plan
- Core Services
- Intensive Health Home Services (IHH only)
- Continuity of Care
- Disenrollment

78.53(6) Payment

- Member must be eligible and enrolled
- A Health Home Service provided during the month
- Maintains documentation
- How to bill

Chapter 79 Amend

79.3 Health Home Services

- Member's eligibility, education on the program, and agree to participate
- Comprehensive assessment
- Comprehensive care management
- Care coordination and health promotion plan
- Comprehensive transitional care plan including appropriate follow-up
- Continuity of care document
- Documentation of member and family support
- Documentation of referral to community and social support services
- Service notes or narratives
- Other documentation as applicable

79.14(2) c

With the application form 470-5273, or as a supplement to a previously submitted application, providers of health home services shall submit Form 470-5100, Health Home Provider Agreement or 470-5160 Integrated Health Home Provider Agreement.

Next Steps

- Review notes from this week
- Review Survey Report
- Deep Dive Provider Standards
- Other States for review (You will want to review other states for our discussions)
  - Department of Social Services (sd.gov)
  - Behavioral health home services / Minnesota Department of Human Services (mn.gov)
  - WV Health Homes